ADULT INTENSIVE OUTPATIENT SERVICES

Definition

The *Montana Medicaid Mental Health Clinical Management Guidelines* (referred to hereafter as the *Clinical Management Guidelines*) for Adult Intensive Outpatient Services defines these services as community-based treatment, with the following Services and Procedure Codes:

HIPPA H0046, Modifier HB (Individual or Family Therapy);
HIPAA H2014 (1:1 Telephone or face-to-face DBT Coaching & Case Management);
and HIPAA H2014, Modifier HQ(DBT Skills Group).

Intensive Outpatient Therapy Services must be provided by individuals or agencies licensed by the State of Montana.

This level of treatment intervention includes a consideration of the person's safety and security needs, including the ability and likelihood of the person to benefit from intensive outpatient treatment.

Prior Authorization Reviews

All Adult Intensive Outpatient Services require prior authorization and must meet medical necessity guidelines as defined in the *Clinical Management Guidelines.* Refer to page AIOS-11 of this section for the complete *Clinical Management Guidelines* specific to Adult Intensive Outpatient. Discussion of the Prior Authorization Review process begins on page AIOS-2 of this section.

Continued Stay Review

All Adult Intensive Outpatient Services that extend beyond the initial authorization date must be authorized through a Continued Stay review. Discussion of the Continued Stay Review process begins on page AIOS-4 of this section.

Retrospective Review

Adult Intensive Outpatient services are not subject to Retrospective Review by First Health Services of Montana except as requested by the Department of Public Health and Human Services, an individual or individual's guardian or provider. This is discussed in detail under the **Retrospective Review** section.

Discharge Procedure

AMDD no longer requires discharge notification form to be completed within 5 business days following patient discharge from services.

PRIOR AUTHORIZATION PROCEDURE

Definition

These services must be medically necessary and advantageous to the client. They are considered as elective treatment. Therefore, prior authorization is required for all Adult Intensive Outpatient services.

Procedure

1. The provider must verify the recipient's Medicaid eligibility.

2. The provider should notify First Health Services of Montana as soon as the need for services is determined, but **must** notify First Health Services of Montana at least 48 hours/two (2) business days prior to initiation of services. This allows for timely completion of the prior authorization review process. This is a fax based notification process for submission of the request for prior authorization and pertinent information. (See FORMS section of this manual for *Prior Authorization Request Form*)

3. The provider must submit a prior authorization request form by fax that includes demographic and clinical information. This information must be sufficient for the clinical reviewer to make a determination regarding medical necessity and must include:

   Demographic information
   - Recipient's Medicaid ID number (MID) number
   - Recipient's Social Security Number (SSN)
   - Recipient's name, date of birth, sex
   - Recipient's address, county of eligibility, telephone number
   - Responsible party name, address, phone number
   - Provider name, provider number, planned date of placement

   Clinical information
   - Prior inpatient treatment
   - Prior outpatient treatment/alternative treatment
   - Anticipated date of service initiation
   - Treatment plan
   - DSM IV diagnosis on Axis I through V
   - Medication history
   - Current symptoms/circumstances requiring Intensive Outpatient services
   - Chronic behavior/symptoms
   - Appropriate medical, social, and family histories
   - Proposed aftercare treatment

6. Upon fax receipt of the above documentation, First Health Services of Montana's clinical reviewer will complete the review process as demonstrated in the *Prior Authorization Flow Chart* (Appendix A).

    - The authorization review will be completed within two (2) business days from receipt of the review request and clinical information providing the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.

        - If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five (5) days of the request for additional information, and

        - The authorization review will be completed within two (2) business days from receipt of additional information

7. If medical necessity is met the First Health Services of Montana reviewer will authorize placement and generate notification to all appropriate parties.

8. If medical necessity is not met, then the case is deferred to a Board-certified psychiatrist in the First Health National Clinical Review Center for review and determination.

CONTINUED STAY REVIEW PROCEDURE

Definition

A continued stay review is a review of currently delivered treatment to determine ongoing medical necessity for a continued level of care.

Reviews of requests for continued stay authorization are based on updated treatment plans, progress notes and recommendations of the individual's treatment team. Continued stay requests require prior authorization and must meet the medical necessity criteria as defined in the *Clinical Management Guidelines* for Intensive Outpatient, Continued Stay Criteria.

Length of Authorization

First Health Services of Montana will conduct continued stay reviews for all medically necessary stays in Intensive Outpatient Services that extend beyond the number of days initially authorized. Each continued stay review may permit authorization of additional treatment when medical necessity is determined. Subsequent continued stay reviews will occur until the recipient is discharged from the service or medical necessity is no longer met.

Procedure

1. The provider is responsible for contacting First Health Services of Montana by fax no more than 5 business days prior to the termination of the initial certification.

2. The provider must submit the following information to complete a continued stay review:

    - Changes to current DSM-IV diagnosis on Axis I through V
    - Justification for continued services at this level of care
    - Behavioral Management interventions/Critical Incidents
    - Assessment of treatment progress related to admitting symptoms and identified treatment goals
    - Current list of medications or rationale for medication changes, if applicable
    - Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan

Continued Stay Review Procedure Continued:

3. Upon fax receipt of the above documentation, First Health Services of Montana's clinical reviewer will complete the review process as demonstrated in the *Continued Stay Flow Chart* (Appendix B).

    - The continued stay review will be completed within two (2) business days from receipt of the review request and clinical information providing the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.

        - If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five (5) days of the request for additional information, and

        - The continued stay review will be completed within two (2) business days from receipt of additional information

4. If medical necessity is met, the First Health Services of Montana reviewer will authorize the continued stay and generate notification to all appropriate parties.

5. If medical necessity is not met then the case is deferred to a Board-certified psychiatrist in the First Health National Clinical Review Center for review and determination.

DETERMINATIONS

Upon completion of the review, one of the following determinations will be applied and notification will be made as outlined in **Notification Process** of this section:

1) **Authorization**:

   An authorization determination indicates that utilization review resulted in approval of all provider requested services and /or service units and issuance of a prior authorization number.

2) **Pending Authorization**:

   Indicates that a First Health Services of Montana reviewer or First Health psychiatrist requires additional information from the provider. Once notified, the provider will have five (5) days to provide any additional information needed to make a payment determination.

3) **Partial Approval**:

   Partial approval is considered an adverse payment determination indicating that the request does not meet the appropriate Medicaid criteria to justify Medicaid payments for the level or complete duration of services requested. Only a First Health psychiatrist may issue a partial approval. Partial approvals are subject to the First Health Services of Montana Appeal process.

4) **Denial**:

   The request for authorization of payment does not meet the appropriate Medicaid medical necessity criteria to justify Medicaid payment for the services requested. Authorization for payment is denied. Only a First Health psychiatrist may issue a denial. Denials are subject to the First Health Services of Montana Appeal process.

5) Technical Denial (Administrative Denial):

   A prior authorization review was not administered on medical necessity criteria as a result of provider Medicaid protocol non-compliance. Non-compliance indicates that the request and/or information was out of specified timeframes or was incomplete. Technical denials may be appealed to the Addictive and Mental Disorders Division within 30 days of date of notification.

NOTIFICATION PROCESS

First Health Services of Montana recognizes the importance of prompt notification of all relevant parties with regard to authorizations and denials. "Relevant parties" is defined as beneficiaries, families or guardians of recipients, requesting providers, and the Department. When appropriate, First Health Services of Montana will notify the regional care coordinator to assist in the transition to other levels of care.

First Health Services of Montana will implement a two-step notification process, providing both informal and formal notification.

Informal Notification

Informal notification will be completed via facsimile on a daily basis and will include:

- Outcome report to the Department of all denials, regardless of region or provider
- Outcome report of all determinations will be given to each provider (Provider specific information only)
- Outcome report of all determinations will be provided to the regional care coordinator (region specific only)

The above outcome reports are generated and transmitted via facsimile by 9:00 AM Mountain Time on the next business day.

Formal Notification

Formal notification will be made providing all relevant parties with a hardcopy determination sent by US mail.

- Authorization and continued stay determinations will be mailed by regular US mail
- Denial determinations (technical denials or denial for medically unnecessary) will be mailed certified return receipt mail and tracked to ensure delivery

Notification Process Continued:

Notifications for technical denial determinations will include:

- Dates of service that are denied a payment because of noncompliance with Administrative Rule
- Reference applicable federal and/or state regulations
- An explanation of the right of the parties to request an Appeal
- Name and address of the person to contact to request an Appeal
- A brief statement of First Health Services of Montana's contractual responsibility to the State of Montana for utilization reviews

Notifications for denial determinations for medically unnecessary treatment/services [ie. services in question are considered medically unnecessary according to Medicaid/MHSP criteria or protocols] will include:

- Dates of service that are denied a payment recommendation based on a lack of medical necessity
- Case specific denial rationale based on the medical necessity criteria upon which the determination was made
- Reference federal and/or state regulations governing the review process
- First Health Services of Montana's date of notice decision, which is the date of printing and mailing; and/or the date of the confirmed facsimile transmission
- An explanation of the right of the recipient (or legal guardian), the psychiatrist/physician, and/or the provider to request an Appeal
- Name and address of person or office to contact to request an Appeal
- A brief statement of First Health Services of Montana's contractual responsibility to the State of Montana for utilization reviews

FIRST HEALTH SERVICES OF MONTANA
APPEAL PROCESS

Definition

Appeal—Consumer, provider, or agent's challenge of a denial. Appeal may be indicated through the use of any one of the following terms: Appeal, Administrative Review, Reconsideration, or Fair Hearing.

Process

All adverse determinations are made by Board-certified psychiatrists. The appeal process is designed to take advantage of Montana-specific knowledge concerning treatment availability, access, and program strengths possessed by our Montana physician panel in the determination process. Therefore, First Health Services of Montana will defer appeals to a Montana-based physician for final determination whenever possible. However, First Health employs a sufficient number of psychiatrists certified by the American Board of Psychiatry and Neurology so that all appeal determinations will be completed by a psychiatrist not involved in the original adverse determination. This process allows for a choice of a peer-to-peer or a desk based review using the following process:

a. Upon receipt of an adverse determination, the recipient or recipient's guardian or the provider/facility may request an appeal of the adverse determination.

b. The request for appeal must be received at the First Health Services of Montana, Helena office within 30 days of the date of receipt of the determination notice.

c. The request for appeal must specify the option of a peer to peer discussion/review or a desk review. Any additional information to be considered must be included with the request.

> **Peer-to-Peer Discussion/Review**:
> Scheduling of peer reviews must be requested and coordinated through the First Health Services of Montana, Helena office. This process must include contact name and numbers for your facility peer, three (3) specific date and time options, and any additional clinical information to support the medical necessity of the services in question. To permit completion of the appeal process within five (5) business days of request receipt, the peer- to-peer discussion will be completed within 72 hours/three (3) business days of request receipt when accompanied by the information requested as above..

Appeal Process Continued:

Desk Review:
A desk review will be performed whenever a peer review has not been requested, when the request for appeal does not specify peer discussion or desk review, or when the appellate physician cannot complete a peer review due to the requestor's unavailability.

d. First Health Services of Montana completes the appeal review within five (5) business days of the receipt of the request. A Board-certified psychiatrist, who has no prior knowledge of the case or professional relationship or ties with the provider, completes the reconsideration review. Whenever possible, Montana licensed and based Board-certified psychiatrists will complete these reviews.

e. All final determinations include rationale for the determination based upon the applicable federal and state regulations, and include instructions as to the rights of further appeal.

f. The determination rendered by the appellate physician performing the review will, in all cases, stand as the final First Health Services of Montana decision.

g. If the appeal review upholds the adverse determination, the rights of the provider and/or the beneficiary to an administrative review or reconsideration with the Montana Department of Public Health and Human Services will be included in the formal notification. First Health Board-certified psychiatrists and licensed psychologists provide input regarding the determination rationale, application of federal and state regulations, and other relevant information.

Please refer to Appendix C for a flow chart detailing the First Health of Montana Appeals Process.

ADULT INTENSIVE OUTPATIENT THERAPY SERVICES
CLINICAL MANAGEMENT GUIDELINES

First Health Services of Montana will employ the use of the Montana Medicaid Clinical Management Guidelines strictly as guidelines. This practical application, coupled with professional judgment based on clinical expertise and national best practices, will enhance the authorization decisions.

Intensive Outpatient Therapy Services represent community-based treatment, with the following Services and Procedure Codes:

HIPPA H0046, Modifier HB (Individual or Family Therapy);
HIPAA H2014 (1:1 Telephone or face-to-face DBT Coaching & Case Management);
and HIPAA H2014, Modifier HQ(DBT Skills Group).

Intensive Outpatient Therapy Services must be provided by individuals or agencies licensed by the State of Montana.

This level of treatment intervention includes a consideration of the person's safety and security needs, including the ability and likelihood of the person to benefit from intensive outpatient treatment.

Admission Criteria

Must meet **each** of the following:

1. The person meets the requirements of (a) or (b). The person must also meet the requirements of (c):
   - (a) has a DSM-IV diagnosis of mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, 293.83, 295.70) with a severity specifier of moderate or severe; **or**
   - (b) has a DSM-IV diagnosis of 301.83 Borderline Personality Disorder, or 301.9 Personality Disorder NOS, with prominent features of 301.83 with a severity specifier of moderate or severe; **and**
   - (c) has ongoing difficulties in functioning because of the mental illness for a period of at least 6 months (or for an obviously predictable period over 6 months), as indicated by:
     - i. dysregulation of emotion, cognition, behavior and interpersonal relationships;
     - ii. resulting in recurrent suicidal, parasuicidal, other serious self-damaging impulsive behaviors, or serious danger to others;
     - iii. a history of treatment at a higher level of care (crisis, emergency room, or hospital services),
     - iv. evidence that lower levels of care are inadequate to meet the needs of the client,

       and

     - v. difficulties in functioning that are not a result of active psychosis.

2. The covered DSM-IV TR diagnosis has been determined through a comprehensive mental health assessment that includes a multi-axial diagnosis on Axes I-V and identifies:
   (a) recipient, family, and community strengths/resources
   (b) a comprehensive evaluation of the recipient's developmental milestones and course
   (c) family dynamics
   (d) past and current school, work, social roles, ability to interact socially
   (e) past and current substance abuse
   (f) past and current legal involvement
   (g) summary of all prior psychiatric hospitalizations, residential program admissions, intensive ambulatory mental health services
   (h) medication trials
   (i) other mental health/psychosocial interventions including an assessment of their degree of success/failure

3. Current symptoms do not meet criteria for a more intensive level of treatment.

4. A lower level of care is inadequate to meet the patient's needs with regard to either treatment or safety.

5. There is a reasonable likelihood of clinically significant benefit as a result of treatment.

6. The recipient has demonstrated intent to form a treatment alliance and comply with mutually identified and agreed upon treatment recommendations.

7. An Individualized Treatment Plan (ITP) has been formulated on admission that identifies specific, realistically achievable goals and measurable objectives that are directed toward the alleviation of the symptoms and/or causes that led to the admission. The recipient's response to treatment has been regularly documented and revisions in the ITP are consistent with the recipient's clinical status.
   The treatment plan must include goals and objectives that address the symptoms in criterion 1 (c) above, and identify the intervention that will be used. The client's crisis plan must be described.

8. Progress toward treatment goals has occurred, as evidenced by measurable reduction of symptoms and/or behaviors that indicate continued responsiveness to treatment.

9. A discharge plan has been formulated, regularly reviewed, and revised. It identifies specific target dates for achieving specific goals, and defines criteria for step-down to a less intensive level of treatment.

Continued Stay Criteria

Must meet **each** of the following:

1. The person meets the requirements of (a) or (b). The person must also meet the requirements of (c) or (d):
   (a) has a DSM-IV diagnosis of mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, 293.83, 295.70) with a severity specifier of moderate or severe; **or**
   (b) has a DSM-IV diagnosis of 301.83 Borderline Personality Disorder, or 301.9 Personality Disorder NOS, with prominent features of 301.83;

   and (c or d)

   (c) has ongoing difficulties in functioning because of the mental illness for a period of at least 6 months (or for an obviously predictable period over 6 months), as indicated by:
      i. dysregulation of emotion, cognition, behavior and interpersonal relationships;
      ii. resulting in recurrent suicidal, parasuicidal, other serious self-damaging impulsive behaviors, or serious danger to others;
      iii. a history of high utilization of crisis, emergency room or hospital services
      iv. evidence that lower levels of care are inadequate to meet the needs of the client;

      and

      v. difficulties in functioning are not a result of active psychosis

      or

   (d) initially met criteria c, but now evidences a reduction of symptoms described in c as above.

2. Current symptoms do not meet criteria for a more intensive level of treatment.

3. A lower level of care is inadequate to meet the patient's needs with regard to either treatment or safety.

4. There is a reasonable likelihood of clinically significant benefit as a result of continued treatment.

5. The recipient and clinician have formed a treatment alliance and active participation towards mutually agreed upon treatment goals is demonstrated. The Individualized Treatment Plan (ITP), formulated on admission and identifying specific, realistically achievable goals and measurable objectives directed towards symptom alleviation continues to be updated to reflect the recipient's response to treatment and is consistent with the recipient's current clinical status.

[The ITP / Individualized Treatment Plan must include goals and objectives that address the symptoms in criterion 1 (c) above, and identify the intervention(s) that will be used. The client's crisis plan must be described.]

6. Progress toward treatment goals has occurred, as evidenced by measurable reduction of symptoms and/or behaviors that indicate continued responsiveness to treatment.

7. A discharge plan has been formulated, regularly reviewed, and revised. It identifies specific target dates for achieving specific goals, and defines criteria for step-down to a less intensive level of treatment.

Discharge Criteria

1. The Individual Treatment Plan goals have been sufficiently met such that the recipient no longer requires this level of care (or)
2. The recipient voluntarily leaves treatment or the beneficiary's legal guardian removes them from the program (or)
3. Recipient no longer meets Medicaid eligibility.